THE CENTRAL AFRICAN JOURNAL OF MEDICINE

Vol. 43, No. 3 March, 1997

CONTENTS

Depression in Zimbabwe: a community approach to prevention and treatment

*J BROADHEAD, *SW ACUDA, **P MBAPE, *G KHUMALO-SAKATUKWA, *M CHIGWANDA, *D O'RYAN, ***E GARURA, **S DODZO, *M MANDABA, *M ABAS

Objective: The collaborative development between primary and secondary care of a community based method for the management and prevention of depression amongst women in a high density suburb of Harare city. ***Design:*** Two stage screening of consecutive primary care attenders, a socio-psychiatric survey of a random community sample of women, an attitude survey among traditional healers, community leaders and depressed people to depression and suicide. Focus group discussions and community workshop to develop a community action plan.

*University of Zimbabwe Depression Research Group
**City Health Department
PO Box 596, Harare
***Harare Psychiatric Unit
†Harare School of Social Work

Correspondence to:
Professor SW Acuda
Department of Psychiatry
University of Zimbabwe Medical School
P O Box A178, Avondale
Harare, Zimbabwe

Setting: Glen Norah high density suburb of Harare city.
Subjects: 432 consecutive primary care attenders, 172 randomly selected women from the community, 10 attitude surveys.
Main outcome measures: Prevalence and causes of depression and a community action plan for prevention
Results: Thirty one per cent of women in the community had been depressed in the previous year and 18% of those attending primary care clinics were currently depressed. Twenty per cent of those in the community had considered or attempted suicide. Onsets of depression were associated with major life events – particularly marital crises and deaths. A simple method for the detection and treatment of depression wa developed.
Conclusion: A large number of women in the community studied suffered from depression caused mainly by social problems. In addition to improved detection and management, a community method of prevention should be implemented.

Introduction

This paper reports on a process whereby research findings, generated by a collaborative project between primary health care workers and a University team, were utilized by a community to formulate local plans for the prevention and management of depression. Action-oriented research, with a high level of community participation, follows on directly from the Declaration of Alma-Ata[1] and has been called Health Systems Research (HSR). The principle of HSR is that it should be useful and have a direct focus on solving practical and relevant problems.[2] Priorities should be generated by health workers and by the community rather than purely by academics and as much as possible of the research should be carried out by those already working at ground level. Results should lead to implementable recommendations and the research is not complete until those recommendations are underway.

Following the Declaration of Alma Ata, Zimbabwe began to develop a nationwide network of primary health care clinics staffed by trained nurses.Through these clinics and through the increased numbers of community psychiatric nurses, the availability of mental health care is being extended.

Harare City Health Department, covering a population of over one million people, runs about 30 primary health care clinics throughout the city. Ten of the largest have a psychiatric nurse. In 1990 the senior psychiatric nurses observed that, of over two million attendances at primary care clinics in Harare, fewer than 5% received a psychiatric diagnosis. They carried out a pilot survey which showed, in contrast, that over 30% of patients, especially women, scored highly on a screening test for psychological symptoms and their impression was that the majority of these were depressed (Mbape,personal communication).

The following priority objectives were then set by the psychiatric nurses:

a. To establish a quick method for primary care workers to detect and diagnose depression.
b. To set out a locally appropriate strategy for primary care workers to treat depression.

In order to fulfil these objectives a number of questions needed to be addressed. Among these was the need to explore the terminology used by traditional healers and by the community to describe syndromes that psychiatrists would recognise as depression. It was crucial to find out how patients who, for example, presented with a headache but wh fitted international diagnostic criteria for depression, describe and viewed their illness.

There were three phases to the project:

1. **Scientific Investigation.**
   a. Of the prevalence of depression in primary healt care clinics.
   b. Of the prevalence and social origins of depressio in the community.
   c. Of the attitudes among traditional healers, community leaders and depressed people t depression and suicide.
2. **Community Workshop.**
   At which results were presented to the members of th community where the research had taken place and a which they, together with primary health care worker formulated recommendations for the prevention an management of depression at local and national level.
3. **Implementation of the Community's Recommendations.**

Scientific Investigation.

a. Prevalence of depression amongst attenders a primary health care clinics.

Method: two stage screening procedure with Self Repor Questionnaire[3] and a Shona translation of the Present Stat Examination[4] of consecutive attenders at primary care clinic (n=432) in South West district of Harare.

Results: 18% of attenders had a psychiatric diagnosis, th commonest of which was depression. Rates were highes amongst those who repeatedly visited clinics and wh presented with multiple physical symptoms.

b. Prevalence and social origins of depression in th community.

Method: random selection of 172 women from the "high density" suburb of Harare called Glen Norah. A two stage screening procedure was used to detect depression. The firs stage instrument used screening questions derived from interviews with traditional healers as well as 'international' criteria and the second stage used the Shona translation of the Present State Examination.[4]

There is now substantial evidence, from Western studies, that certain types of 'provoking agent', i.e. life events and long standing difficulties associated with severe threat, frequently precede the onsets of episodes of depression and have a causal role.[5] Life events and difficulties were elicited

and rated using the Life Events and Difficulties Schedule [5] adapted for use in the Zimbabwean situation. Interviews were carried out by the Zimbabwean Shona speaking members of the research team (i.e. authors PM, GK-S, MC, SD, MM) who had been trained in use of the LEDS. Socio-demographic type information and social support data were also collected.

Results:

Women's own language for emotional distress: Of 50 women later shown to be cases of depression, 51 different terms were volunteered to describe the way they had been feeling (at a time identified by the first stage interview when they had been emotionally distressed and/or following significant stressors). Although 61% of these terms were physical (e.g. weakness, pain moving through body), psychological terms were most frequently used. Two thirds described "thinking too much" or "thinking a lot" (*kufungisisa*), which has negative connotations conveying dwelling on troubled thoughts and decreasing one's normal activities. Thinking too much was also viewed as the cause of other symptoms such as lack of sleep and chest pain. Forty nine per cent volunteered deep sadness (*kusuwisia*).The "normal" sadness associated with grieving was called *kuchema*. Although 57% offered symptoms related to the heart, these fell into different categories e.g. 42% of cases described *hana kurova zvakanyanya*, conveying a feeling of fear or uncertainty. A quarter described a painful heart,(*mwoyo unorwadza*) or a heavy lump sitting on the heart. It was seen with bereavement, but also followed rejection or being let down. Others spoke of "my heart is aching" (*mwoyo wangu uri kurwadza*) indicating disappointment. 36% volunteered poor sleep and 34% headaches which were constant "as though I am carrying a stone on my head" or "as though my head is full of water".

Annual prevalence and incidence of depression: 31% of women in the random community sample had suffered a depressive illness, for an average of four months, in the year before interview and 20% had considered or attempted suicide. The annual incidence of depression was 18%.

Prevalence of severe life events and major difficulties: Of women in Glen Norah, 54% had a severe event and 29% a major difficulty in a one year period.

Nature of severe life events: 23% of severe life events were marital crises, 21% were non-marital relationship crises, 18% were deaths of important people and 10% were illnesses and accidents.

Nature of major difficulties: 26% of major difficulties were marital, 21% were non-marital relationship problems, 24% were financial difficulties and 15% were the result of bad housing.

Socio-demographic type variables and severe events: Having severe events was predicted by having a poor marital relationship and living in overcrowded accommodation (>9 people per house).

Severe life events and the onset of depression: 97% of onsets of depression were preceded by a severe life event or major life difficulty. This compared with 41% of non-depressed women who had a severe life event and confirms the critical role of life events in the onset of depression in Harare.

Rates of onset of depression following severe events: 29% of women who had a severe event became depressed as a result.

Vulnerability to depression: Women who had a severe event were significantly more likely to become depressed if they had been separated from their mother for more than one year during childhood and if they had no support from their named *tete*, who was usually their paternal aunt. Thirty six per cent of the sample had been separated from their mothers and the commonest reason for this was the practice of sending children to live with other relatives. Fifty one per cent of women had no support from tete usually as a result of geographical separation. Women who had both the vulnerability factors had a 65% chance of becoming depressed following a severe event.

Chronicity of depression: Having a relationship difficulty that had lasted at least six months before the onset of depression predicted an episode lasting longer than six months.

Health service usage by depressed women identified in the random sample: 63% of depressed women had sought help only from family, friends or the church; 29% had asked for help for symptoms at a primary care clinic of whom 80% were prescribed paracetamol and 13% diazepam. Many women knew there was a psychiatric nurse at the clinic but had not asked to see her and had not been offered a referral. They felt that she was for "real madness" but indicated that they would have been willing to see a clinic nurse designated to discuss "family problems" privately. Ninetten per cent sought help from a traditional healer or a religious healer. Fourteen per cent consulted a private GP, of these 43% were prescribed diazepam and one woman received "tablets for appetite". No one had received an antidepressant.

Details of the method and results of this community socio-psychiatric survey can be found in other publications.[6,7,8]

c. Attitudes among traditional healers, community leaders and depressed people to depression and suicide.

Method: interviews with community figures (n=100) such as school teachers, police, housing officers, community health workers, church leaders and traditional healers using a case vignette of depression and a questionnaire.

Results: community members produced good guidelines for counselling and outlined the great resources that already exist within the community for the management of depression and social difficulties.

Community Workshop.

The workshop took place in March 1992 allowing members of the Glen Norah community to meet nurses, doctors and health educators from the Harare City Health Department and with representatives of a number of governmental and non-governmental organizations.

The research findings were presented in the form of answers to a series of questions e.g. how common is *kufungisisa*-depression? Does it matter that women are depressed? How might people with *kufungisisa*-depression be helped? A logo was used to illustrate the spectrum of happiness through to clinical depression, showing the potential to recover from severe misery. A number of vivid but disguised case histories were used to illustrate causes and consequences of depression.

Treatment was discussed under four headings, namely counselling, giving practical help, nutrition and medication. The framework used was to combine findings from the community attitude survey and suggestions from the depressed

women, with guidelines from traditional healers and from modern psychiatry. For example under counselling, the Shona terms of "giving comfort" and "giving advice" were discussed in combination with encouraging the person to talk and to express bad feelings. If trusted, the paternal aunt, or *tete*, was still felt to be the best family member to provide counselling and to be involved in solving problems although women in the urban situation were clearly turning increasingly to a friend of their own making. Institutions associated with skilled counselling were the church and the department of social welfare and the qualities of a good counsellor were listed. Issues of confidentiality at clinics were raised, together with the possibility of having someone at a clinic designated to discuss family problems.

Following presentation of the research findings, the participants were divided into groups, so bringing together community members and health workers with policy makers. Groups were conducted mostly in Shona with interpreters for non-Shona speakers. Each group was given a topic to discuss and was asked to formulate recommendations for action.

The topics were as follows:

1. Prevention.
   How can *kufungisisa* depression be prevented at the following levels: family, community, local services eg church, social welfare, police, schools, clinics etc.,government / national.
2. Education.
   What do the community, local services, and national services need to know about *kufungisisa*-depression and suicide? How can awareness be raised and education be improved at community and national levels?
3. Training.
   How can the various sectors in the community eg churches, police, women's groups etc. receive, give and share training on *kufungisisa*-depression? What training is required? What support can these sectors give to people with *kufungisisa*-depression?
4. Health and Social Services.
   Which ways can the health services and the social welfare services improve detection and management of kufungisisa at an urban and a rural level?
5. Treatment.
   Discussion of three case histories. What should be the step by step stages of helping and counselling these people?

At the end of the day, rapporteurs summarized the main discussions that had taken place and the recommendations from each group. The participants were clearly enthusiastic and their response appeared to reflect an acknowledgement that the issues raised demanded much further attention. The extensive list of recommendations, for both short term and longer term implementation, have been published in full for local use.[8] They range from promoting improved marital relationships by such means as premarital counselling and the setting up of "couples clubs", to the use of written material and live drama in outlining what the public and health care workers need to know about depression and suicide. Given the increasing fragmentation of the extended family it was felt that parents needed to take over the role, previously assumed by a paternal aunt, of marital instruction and negotiation. Accessible education was felt to be crucial in enhancing the status of women, as was empowering them to utilise the legal system. Clinics were to allocate a private room for confidential discussion of problems and a directory was to be compiled and published to improve networking between the helping agencies. The function of traditional healers, church leaders, teachers and the media was highlighted in providing "education for living " especially given the distortions of cultural values that can take place in the urban environment.

Implementation of Results.

One of the recommendations was to improve detection and treatment of depression in primary health care clinics. Using findings from the clinic study, the "Multiple Symptom Card" has been produced which focuses nurses on patients with the commonest presentations of depression. Once alerted the nurse follows an algorithm for diagnosing "probable depression" which requires her to observe facial expression and speech and to ask four questions to assess mood. The reverse of the card outlines a Seven Step Plan for management which combines the community's recommendations on "listening and talking" with exploration of social problems and involvement of resources outside the clinic. Guidelines are given on the appropriate use of amitriptyline together with the need to investigate and treat additional physical illness. The Harare City Health Department has begun using the card and grants have been applied for to evaluate its efficacy.

Another recommendation made was that materials be produced to stimulate discussion in women's groups, schools and church circles. A pamphlet has been produced (available from the University of Zimbabwe Department of Psychiatry) which gives information about depression and heightens awareness of social situations which are likely to cause it. It de-mystifies the condition in line with traditional healers' beliefs that "thinking too much" occurs in people who "cannot solve their problems" and is different from mental illness caused by witchcraft or spirit possession, giving confidence that change can often be achieved through simple commonsense approaches. Given the enhanced power of drama and song, a dramatized version of the pamphlet and of the workshop recommendations is being produced by a team of community workers. The Zimbabwe National Association for Mental Health plans to promote the community teaching materials and is applying for funding to sponsor further drama and to produce a directory of agencies to enabling appropriate and efficient referral from clinics.

Conclusions: Harare City Health Department were concerned that up to a quarter of two million attendances per year at its primary health care clinics could be related to psychological factors. Research confirmed that more than 15% of attenders had psychiatric disorders and that a significant proportion of these had attended the clinic on numerous occasions, so taking up a great deal of nursing time but without a correct diagnosis being made or appropriate treatment given.

In addition a very high prevalence of depression was found among women in the community, many of whom were turning for support to the family and to agencies other than health clinics, although this situation may change with increasing urbanization. The rates of depression found, although high, are compatible with figures from other African

studies[10] and from Western studies of young, urban-dwelling women.[5] Treatment for depression does exist and, as well as addressing inappropriate use of health worker time in carrying out needless investigations and prescribing unsuitable drugs, can relieve distress and reduce associated disability.[11] In a country with economic problems and infectious diseases affecting large numbers of the workforce, it may be increasingly relevant to optimize mental as well as physical health.

One of the problems in implementation of the recommendations generated as part of this study will be the low numbers of mental health specialists currently working in Zimbabwe. There is an extensive network of hospitals and clinics throughout the country and, through training of medical and nursing staff, existing resources could be strengthened but this process will require careful planning and support of staff working in relative isolation. Visiting specialists might play a temporary role in facilitating appropriate training but must be ready to be guided by local priorities in teaching and research.

Another block in the development of psychiatric services has traditionally been the stigma associated with mental illness. Nevertheless we found health workers highly motivated to address the problem of patients with "multiple symptoms". Possibly an important way forward in promoting mental health will be through the minor psychiatric illnesses which are easier to identify with and less associated with supernatural causes. Another approach should be to integrate with an established health priority thus this study allied itself with Zimbabwe's highly developed programme in Maternal and Child Health.

The most important aspect in implementation will come from the interest and commitment generated by community participation. This process highlighted the considerable resources already available for the management of depression. Moreover it was quite clear that community leaders and depressed women viewed depression in a mainly non-medical way and saw a vital role for a range of community services to become involved in providing effective care and in planning prevention. Without their involvement it would have been impossible to formulate a comprehensive strategy which generated confidence in local health workers. We would argue that guidelines from international agencies have a limited role and can only be effective when combined with locally generated recommendations. Involvement of the community in formulation of implementable recommendations is more likely to lead to sustainable change because the recommendations come from the people who actually develop and use the services. Although medical services have contact with depressed people it is evident that issues of prevention and treatment can only be appropriately addressed by wider social changes and through further facilitation of community action.

Acknowledgements

We would like to thank the University of Zimbabwe Department of Psychiatry, Dr J Mutambirwa for guidance. We thank Dr OL Mbengeranwa, Chief Medical Officer of Harare City Health Department, who saw the need for work on depression and allowed this work to take place. We thank all those nursing staff from the Harare City Health Department, especially Matron Gwata, who were involved in the primary care study. We are indebted to NORAD, GTZ and the MacArthur Foundation for sponsorship and ZIMNAMH for administration. We are grateful to Professor George Brown and to Tirril Harris for their time and support.

References

1. World Health Organisation. Alma Ata 1978: Primary health care. Report of the International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978, Geneva.
2. Taylor CE. The uses of health systems research. Public Health Papers, Geneva, WHO, 1984.
3. Harding TW, *et al.* Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. *Psychol Med* 1980;10:231-41.
4. Wing JK, Cooper JE, Sartorius N. Description and classification of psychiatric symptoms. London: Cambridge University Press, 1974.
5. Brown G, Harris TO. Social origins of depression. Tavistock Press, 1978.
6. Abas MA, Broadhead JC. Depression and anxiety among women in an urban setting in Zimbabwe, Africa. *Psychol Med* 1977;27:59-71.
7. Broadhead JC, Abas MA. Life events and difficulties and the onset of depression among women in an urban setting in Zimbabwe (in press).
8. Proceedings of a community workshop on mental health research. Harare: Matthews Printers, 1992.
9. Broadhead J, Abas MA. Depressive illness in Zimbabwe. *Trop Doctor* 1994;24:27-30.
10. Orley J, Wing JK. Psychiatric disorders in two African villages. *Arch Gen Psychiatr* 1979;36:513-20.
11. Eisenberg L. Treating depression and anxiety in primary care. *N Engl J Med* April 16 1992 April 16;1080-4.